

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16196

16183

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN		c. LENGTH OF STAY IN 1b 76 YRS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 314 Bay ST	
3. NAME OF DECEASED (Type or print) First John Middle C Last CROPPER		4. DATE OF DEATH Month Nov. Day 27 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 25, 1890
9. AGE (In years lost birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY HEALING PRODUCTS	
11. BIRTHPLACE (County & State, or foreign country) BERLIN MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS CROPPER		14. MOTHER'S MAIDEN NAME ANNIE McCABE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-32-7015	
17. INFORMANT MRS. JOHN C. CROPPER		Address BERLIN MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 4222 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 25 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid arthritis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1950 , 19 11-29 , 19 67 , that (I) (we) last saw the deceased alive on 11-26 , 19 67 , and that death occurred at 5 M, from causes and on the date stated above.			
22a. SIGNATURE Frank Lewis		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Frank Lewis		22d. ADDRESS Millards Maryland	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/29/67	
23c. NAME OF CEMETERY OR CREMATORY EVERGREEN		23d. LOCATION (City or Town) (County) (State) BERLIN WOR MD	
24. FUNERAL DIRECTOR Anna D. Burbage Berlin Md.		25a. REC'D BY REGISTRAR DEC 4 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

54102

10/24/1967

Chlorophyll *a*

11.1 mg/L

11.1 mg/L

11.1 mg/L

11.1 mg/L

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16195

16184

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>WOR</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Berlin</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Berlin</u> 23-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>R 3 Box 146 Branch St</u>		d. STREET ADDRESS <u>R 3 Box 146 Branch St</u>	
3. NAME OF DECEASED (Type or print) <u>J. CARL</u> First Middle Last		4. DATE OF DEATH <u>Nov 27</u> 19 <u>67</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/2/1887</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waiter</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219 14 3305</u>	
17. INFORMANT <u>Joseph F. Lewis</u>		88 Address <u>Lincoln Apt. Frederick, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Disease</u> DUE TO (c) <u>ASCVD</u>			INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u> <u>years.</u> <u>years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>F.J. Townsend, Jr.</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>F.J. Townsend, Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/1/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ever Green Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Berlin Worcester Md.</u>	
24. FUNERAL DIRECTOR <u>Clinton F. Stewart - Salie - Md.</u> ADDRESS		25a. REC'D BY REGISTRAR <u>DEC 4 1967</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

22. DATE SIGNED

Nov 27, 67

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16196

CERTIFICATE OF DEATH

16185

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill		c. LENGTH OF STAY IN 1b Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 1		d. STREET ADDRESS Route #1	
3. NAME OF DECEASED (Type or print) First JAMES Middle DAVID Last HESSENAUER JR.		4. DATE OF DEATH Month November Day 29 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1906
9. AGE (In years lost birthday) 61 yrs.		IF UNDER 1 YEAR Months 61 Days 61 Hours 61 Min. 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY Baltimore	
11. BIRTHPLACE (County & State, or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James D. Hessenauer		14. MOTHER'S MAIDEN NAME Elizabeth Stahm	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Address H.D. 1	
17. INFORMANT Mrs. Mary A. Hessenauer, Cambridge, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY OCCLUSION 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO SCLEROTIC HEART DISEASE DUE TO (c) 40 YEARS		INTERVAL BETWEEN ONSET AND DEATH 30 MIN SEVERAL 40 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/29/67 , 19 to 11/29/67 , 19, that (I) (we) last saw the deceased alive on 11/29/67 , 19, and that death occurred at 6:45 PM , from causes and on the date stated above.			
22a. SIGNATURE Robert C. La Mar		22b. DATE SIGNED 11/29/1967	
22c. PHYSICIAN'S NAME (Type) Robert C. La Mar MD		22d. ADDRESS Bay St. Snow Hill, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 2, 1967	
23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Ullrich Funeral Home, Baltimore, Md.		25a. REC'D BY REGISTRAR DEC 4 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

1915

DEPARTMENT OF DEW

1915

ACTIVE RECORDS FROM DISTRICT
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ACTIVE RECORDS FROM DISTRICT

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**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm 5 may be retained for your files.

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VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16197

16186

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WOR</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Ocean City</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Ocean City</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Showells Motel - Route 1 Ocean City</u>				d. STREET ADDRESS <u>Route 1 - Box 386</u>			
3. NAME OF DECEASED (Type or print) <u>Carmelia Elizabeth Hilliard</u>				4. DATE OF DEATH <u>Nov. 24</u> 19 <u>67</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/5/55</u>		9. AGE (In years last birthday) <u>12</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert Hilliard</u>				14. MOTHER'S MAIDEN NAME <u>Arline Rowe</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Albert Hilliard</u> Address <u>Rt Ocean City, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GUNSHOT wound Rt upper chest</u> DUE TO (b) <u>thru ascending aorta.</u> DUE TO (c) <u>Instant</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Friend accidentally discharged 410 shot gun.</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>12:45</u> p.m. <u>Nov 24</u> 19 <u>67</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Ocean City WOR MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE <u>[Signature]</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED	
EXAMINER'S NAME (Type) <u>FJ Townsend, Jr</u>		<u>Ocean City, Md.</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		<u>Nov 24, 67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11-29-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>		23d. LOCATION (City or Town) (County) (State) <u>Berlin WOR MD</u>	
24. FUNERAL DIRECTOR <u>Coretta B. Jolley</u> Address <u>Salisbury, Md.</u>				25a. REC'D BY REGISTRAR <u>NOV 30 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

The first of these is the
 fact that the population of
 the area is increasing rapidly.
 This is due to the fact that
 the area is becoming more
 attractive to people who
 are looking for a better
 place to live. The second
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 to people who are looking
 for a better place to live.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16198 Film G395 12/12/CERTIFICATE OF DEATH

16187

1. PLACE OF DEATH a. COUNTY WORCESTER b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BERLIN c. LENGTH OF STAY IN 1b 231 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) RD 2				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BERLIN d. STREET ADDRESS RD 2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH JAMES LUTZ				4. DATE OF DEATH Month Day Year Nov 30 1967			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG 25, 1904	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Mins.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER & ELECTRICIAN SELF EMP				10b. KIND OF BUSINESS OR INDUSTRY SELF EMP		11. BIRTHPLACE (County & State, or foreign country) CHESTER PA	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME ADOLPH LUTZ				14. MOTHER'S MAIDEN NAME PAULINE (unmarried)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT Mrs J. J. LUTZ		Address BERLIN MD RD 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA 1621 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 1 year
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Nov 23 1967				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State) BERLIN MD							
21. I certify that (I) (this hospital) attended the deceased from JAN 23 1967 to Nov 1967 , that (I) (we) last saw the deceased alive on Nov 21 1967 , and that death occurred at 4:57 P.M. from the causes and on the date stated above.							
22a. SIGNATURE [Signature]				22b. DATE SIGNED Dec 1, 1967			
22c. PHYSICIAN'S NAME (Type) F S TOWNSEND JR				22d. ADDRESS Ocean City Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/3/67		23c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL		23d. LOCATION (City, town or county) (State) BERLIN MD	
24. FUNERAL DIRECTOR Anna A. Burbage				25a. REC'D BY REGISTRAR DEC 5 1967		25b. REGISTRAR'S SIGNATURE [Signature]	

10181

UNITED STATES GOVERNMENT

OFFICE OF THE SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301

MEMORANDUM FOR THE SECRETARY OF DEFENSE

SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

25. [Illegible]

26. [Illegible]

27. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers—Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16199

16188

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin		c. LENGTH OF STAY IN 1b 23-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Berlin Nursing Home		d. STREET ADDRESS 23-1	
3. NAME OF DECEASED (Type or print) First Middle Last SADIE E. MADDOX		4. DATE OF DEATH Month Day Year November 10 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/21/1882
9. AGE (In years lost birthday) yrs. 85		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Major Pruitt		14. MOTHER'S MAIDEN NAME Mahley Elizabeth Curtis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mrs. Gladys Wooster,		Address Pocomoke City, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO Carcinoma of Breast (b) Diabetes mellitus DUE TO Cerebral sclerosis (c) Cerebral sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 2 , 19 67 , to Nov 16 , 19 67 , that (I) (we) last saw the deceased alive on Nov 16 , 19 67 , and that death occurred at 7 A M, from causes and on the date stated above.			
22a. SIGNATURE Charles R Law		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Charles Law MD.		22d. ADDRESS Berlin Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/19/1967	
23c. NAME OF CEMETERY OR CREMATORY Beth Eden		23d. LOCATION (City or Town) (County) (State) Worcester, Md.	
24. FUNERAL DIRECTOR Gerald C. Sound		25a. REC'D BY REGISTRAR DATE NOV 21 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

8826

RECORD OF DEATH

1010

NAME		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTERED		FILED		INDEXED		SERIALIZED		RECEIVED		DATE		TIME		BY		OFFICE		COUNTY		STATE		FEDERAL BUREAU OF INVESTIGATION		DEPARTMENT OF JUSTICE		WASHINGTON, D. C.		1900		1910		1920		1930		1940		1950		1960		1970		1980		1990		2000		2010		2020		2030		2040		2050		2060		2070		2080		2090		2100		2110		2120		2130		2140		2150		2160		2170		2180		2190		2200		2210		2220		2230		2240		2250		2260		2270		2280		2290		2300		2310		2320		2330		2340		2350		2360		2370		2380		2390		2400		2410		2420		2430		2440		2450		2460		2470		2480		2490		2500		2510		2520		2530		2540		2550		2560		2570		2580		2590		2600		2610		2620		2630		2640		2650		2660		2670		2680		2690		2700		2710		2720		2730		2740		2750		2760		2770		2780		2790		2800		2810		2820		2830		2840		2850		2860		2870		2880		2890		2900		2910		2920		2930		2940		2950		2960		2970		2980		2990		3000		3010		3020		3030		3040		3050		3060		3070		3080		3090		3100		3110		3120		3130		3140		3150		3160		3170		3180		3190		3200		3210		3220		3230		3240		3250		3260		3270		3280		3290		3300		3310		3320		3330		3340		3350		3360		3370		3380		3390		3400		3410		3420		3430		3440		3450		3460		3470		3480		3490		3500		3510		3520		3530		3540		3550		3560		3570		3580		3590		3600		3610		3620		3630		3640		3650		3660		3670		3680		3690		3700		3710		3720		3730		3740		3750		3760		3770		3780		3790		3800		3810		3820		3830		3840		3850		3860		3870		3880		3890		3900		3910		3920		3930		3940		3950		3960		3970		3980		3990		4000		4010		4020		4030		4040		4050		4060		4070		4080		4090		4100		4110		4120		4130		4140		4150		4160		4170		4180		4190		4200		4210		4220		4230		4240		4250		4260		4270		4280		4290		4300		4310		4320		4330		4340		4350		4360		4370		4380		4390		4400		4410		4420		4430		4440		4450		4460		4470		4480		4490		4500		4510		4520		4530		4540		4550		4560		4570		4580		4590		4600		4610		4620		4630		4640		4650		4660		4670		4680		4690		4700		4710		4720		4730		4740		4750		4760		4770		4780		4790		4800		4810		4820		4830		4840		4850		4860		4870		4880		4890		4900		4910		4920		4930		4940		4950		4960		4970		4980		4990		5000		5010		5020		5030		5040		5050		5060		5070		5080		5090		5100		5110		5120		5130		5140		5150		5160		5170		5180		5190		5200		5210		5220		5230		5240		5250		5260		5270		5280		5290		5300		5310		5320		5330		5340		5350		5360		5370		5380		5390		5400		5410		5420		5430		5440		5450		5460		5470		5480		5490		5500		5510		5520		5530		5540		5550		5560		5570		5580		5590		5600		5610		5620		5630		5640		5650		5660		5670		5680		5690		5700		5710		5720		5730		5740		5750		5760		5770		5780		5790		5800		5810		5820		5830		5840		5850		5860		5870		5880		5890		5900		5910		5920		5930		5940		5950		5960		5970		5980		5990		6000		6010		6020		6030		6040		6050		6060		6070		6080		6090		6100		6110		6120		6130		6140		6150		6160		6170		6180		6190		6200		6210		6220		6230		6240		6250		6260		6270		6280		6290		6300		6310		6320		6330		6340		6350		6360		6370		6380		6390		6400		6410		6420		6430		6440		6450		6460		6470		6480		6490		6500		6510		6520		6530		6540		6550		6560		6570		6580		6590		6600		6610		6620		6630		6640		6650		6660		6670		6680		6690		6700		6710		6720		6730		6740		6750		6760		6770		6780		6790		6800		6810		6820		6830		6840		6850		6860		6870		6880		6890		6900		6910		6920		6930		6940		6950		6960		6970		6980		6990		7000		7010		7020		7030		7040		7050		7060		7070		7080		7090		7100		7110		7120		7130		7140		7150		7160		7170		7180		7190		7200		7210		7220		7230		7240		7250		7260		7270		7280		7290		7300		7310		7320		7330		7340		7350		7360		7370		7380		7390		7400		7410		7420		7430		7440		7450		7460		7470		7480		7490		7500		7510		7520		7530		7540		7550		7560		7570		7580		7590		7600		7610		7620		7630		7640		7650		7660		7670		7680		7690		7700		7710		7720		7730		7740		7750		7760		7770		7780		7790		7800		7810		7820		7830		7840		7850		7860		7870		7880		7890		7900		7910		7920		7930		7940		7950		7960		7970		7980		7990		8000		8010		8020		8030		8040		8050		8060		8070		8080		8090		8100		8110		8120		8130		8140		8150		8160		8170		8180		8190		8200		8210		8220		8230		8240		8250		8260		8270		8280		8290		8300		8310		8320		8330		8340		8350		8360		8370		8380		8390		8400		8410		8420		8430		8440		8450		8460		8470		8480		8490		8500		8510		8520		8530		8540		8550		8560		8570		8580		8590		8600		8610		8620		8630		8640		8650		8660		8670		8680		8690		8700		8710		8720		8730		8740		8750		8760		8770		8780		8790		8800		8810		8820		8830		8840		8850		8860		8870		8880		8890		8900		8910		8920		8930		8940		8950		8960		8970		8980		8990		9000		9010		9020		9030		9040		9050		9060		9070		9080		9090		9100		9110		9120		9130		9140		9150		9160		9170		9180		9190		9200		9210		9220		9230		9240		9250		9260		9270		9280		9290		9300		9310		9320		9330		9340		9350		9360		9370		9380		9390		9400		9410		9420		9430		9440		9450		9460		9470		9480		9490		9500		9510		9520		9530		9540		9550		9560		9570		9580		9590		9600		9610		9620		9630		9640		9650		9660		9670		9680		9690		9700		9710		9720		9730		9740		9750		9760		9770		9780		9790		9800		9810		9820		9830		9840		9850		9860		9870		9880		9890		9900		9910		9920		9930		9940		9950		9960		9970		9980		9990		10000		10010		10020		10030		10040		10050		10060		10070		10080		10090		10100		10110		10120		10130		10140		10150		10160		10170		10180		101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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16200

CERTIFICATE OF DEATH

16189

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Worcester</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stockton</u> c. LENGTH OF STAY IN 1b <u>6 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ---				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stockton</u> <u>237</u> d. STREET ADDRESS ---			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH FREDERICK MILES</u>			4. DATE OF DEATH Month Day Year <u>November 9 1967</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1900</u>	9. AGE (In years lost birthday) yrs. <u>67</u>	IF UNDER 1 YEAR Months Days Hours Min. ---		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto Factory</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Accomack County, Virginia</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Robert Miles</u>				
14. MOTHER'S MAIDEN NAME <u>Minnie Bundick</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				
16. SOCIAL SECURITY NO. <u>159-07-4180</u>		17. INFORMANT Address <u>Mrs Geneva Miles, Stockton, Maryland</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4201</u> DUE TO (b) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. --- 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) ---	21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>65</u> to <u>Nov 9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov 9</u> , 19 <u>67</u> , and that death occurred at <u>5P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Isaac S White</u>		22b. DATE SIGNED <u>Nov 10, 67</u>		22c. PHYSICIAN'S NAME (Type) <u>Isaac S White, MD</u>			
22d. ADDRESS <u>1310 Xom, Va.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					
23b. DATE THEREOF <u>11-13-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gunby Presbyterian</u>		23d. LOCATION (City or Town) (County) (State) <u>Stockton - Worcester-Md.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Robert H. Watson</u> <u>Pocomoke City, Md.</u>			25a. REC'D BY REGISTRAR <u>NOV 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

10198

CERTIFICATE OF DEATH

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NOTE: This is a copy of the original certificate of death. It is not to be used for legal purposes. The original certificate of death is the only one that is valid for legal purposes. The original certificate of death is the only one that is valid for legal purposes.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16201

CERTIFICATE OF DEATH

16190

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pocomoke</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>		221	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>R.F.D. 2 Box 90</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Pauline R. Purnell</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>4</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22, 1904</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Wife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Dennard Rowley</u>				14. MOTHER'S MAIDEN NAME <u>Bertie Gumbly</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>513-16-8363</u>		17. INFORMANT <u>Margaret Ginn</u> Address <u>R.F.D. 2 Pocomoke, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X Uremia</u> DUE TO (b) <u>diabetic Nephropathy</u> DUE TO (c) <u>Diabetes Mellitus</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 mo. Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>66</u> , to <u>Nov.</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Sept</u> 19 <u>67</u> , and that death occurred at <u> </u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>David Raper</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DAVID RAFA</u>				22d. ADDRESS <u>SNOW HILL Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-8-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Shiloh Meth. Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Pocomoke Wor. Md.</u>	
24. FUNERAL DIRECTOR <u>Samuel S. Jones</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16191

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL NEWARK</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potts Landing</u>		d. STREET ADDRESS <u>ROXANA</u>	
3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>EVANS</u> Middle <u>Wilgus</u> Last		4. DATE OF DEATH <u>Nov</u> Month <u>21</u> Day <u>19</u> Year <u>67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/29/15</u> 52 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Executive</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chicken</u>	11. BIRTHPLACE (State or foreign country) <u>Roxana, Del.</u>
13. FATHER'S NAME <u>HARRY F. Wilgus</u>		14. MOTHER'S MAIDEN NAME <u>VALERIA EVANS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-20-6195</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning, Accidental</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>9298</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>DROWNED IN bay - FOUND LATER.</u>	
20c. TIME OF INJURY Month, Day, Year <u>Approx Nov 21 19 67</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bay</u>		20f. (City or town) (County) (State) <u>Rural Newark Wor Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>F. J. Townsend, Jr.</u> M.D.		22. DATE SIGNED <u>Nov 22, 67</u>	
EXAMINER'S NAME (Type) <u>F. J. TOWNSEND, JR</u>		DEPUTY MEDICAL EXAMINER <u>Ocean City, Del</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11-25-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WILGUS CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>ROXANA, SUSSEX, DEL</u>
24. FUNERAL DIRECTOR <u>G. Douglas Nelson, Frankford, Del.</u> ADDRESS		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
		DATE <u>NOV 30 1967</u>	

